

JUNE 28, 2004

Adolescents, Alcohol and Drugs: The Sooner You Teach Them, the Better

When Francine Hahn Haight, a nurse in La Mesa, **California**, returned home from running errands in February 2001, she ran upstairs to see why her son was still in bed. She found that 18-year-old Ryan, a 4.0-grade-point-average student and Varsity tennis player, wasn't breathing. "I could not believe what I saw," Haight said. "I knew he was dead."

Haight performed CPR but neither she nor the paramedics could bring Ryan back. A sheriff arrived on the scene and showed her what he'd found in Ryan's room: a vial of hydrocodone (Vicodin) and a bottle of morphine, both of which he'd obtained through the Internet. Not knowing its power, he had overdosed on hydrocodone.

Most youngsters don't die from experimentation with alcohol and drugs. But those who do leave their loved ones with unending grief, Ryan's mother told a U.S. Senate committee in June. "We parents often worry about our children," she said. "When they are little we worry they will fall and get hurt. But as they become teenagers we worry even more."

Indeed, there is much to worry about, and the worries differ from family to family and state to state. In **Nebraska**, for example, "alcohol is the number one drug of choice," said Sen. Jim Jensen. "But methamphetamine is very, very strong. It's very cheap to buy and kids can get the recipe for it on the Internet. Young people are always looking for something that's new or different, and meth is something they can get into very easily." In addition, Jensen said, "ditch weed," or wild marijuana, grows in the fields. (*SHN* will do a separate story in the near-future on methamphetamine.)

Nationally, young people have reduced their overall use of alcohol, tobacco and illicit drugs, according to the 2003 "Monitoring the Future" survey of 8th-, 10th-, and 12th-graders by the National Institute on Drug Abuse (NIDA). Kids decreased their use of MDMA or Ecstasy by almost 50 percent over from 2001 to 2003, and tobacco use was the lowest in the 28-year history of the survey. Methamphetamine use also has gradually declined.

But the number of adolescents who abuse prescription painkillers has been increasing. Last year, one in ten twelfth-graders abused the drug that killed Ryan Haight. Nearly five percent of 12th graders used Oxycontin for non-medical reasons. And while alcohol use has been dropping, many continue to drink. Forty-eight percent of 12th-graders said they'd had a drink within the previous 30 days. Three million kids have serious alcohol problems, but fewer than 20 percent enter treatment, according to Eric Goplerud, PhD, director of Ensuring Solutions to Alcohol Problems (ESAP), at the George Washington University in Washington, D.C.

ESPECIALLY VULNERABLE

Experts in substance use disorders focus on adolescents for a reason -- and it's not just because they're children and prone to risk-taking. "The adolescent brain is very plastic, and it changes in response to the environment," Nora Volkow, M.D., director of NIDA, told a recent conference held by NCSL's Health Chairs Project. In other words, the adolescent brain is undergoing growth and changes that makes it especially susceptible to biochemical changes brought on by substance use. Preliminary data from studies show that early substance use increases the risk of developing schizophrenia and depression, Volkow said.

Other studies show that early use also increases the likelihood that a youngster will develop a substance use disorder that will continue into adulthood. More than 90 percent of adults with substance use disorders started using before the age of 18, and half of those began before age 15,

[*Substance Use*, p.2]

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Cardiovascular disease kills more women than cancer. Women are 20% more likely to die in the hospital following a heart attack than men.

State Health Notes is supported in part by a grant from the Robert Wood Johnson Foundation.

according to Physicians and Lawyers for National Drug Policy (PLNDP), an advocacy group for science-based drug policies.

Of the 2.1 million people who in 1999 met the criteria for alcohol or drug dependence, 791,581 (22 percent) were adolescents and 771,256 (21 percent) were young adults.

There is good news. Substance use experts have developed programs that can prevent, delay or stop substance use before it progresses to dependence or addiction.

The experts know that certain “protective factors” make it less likely that a child will start using substances. These include strong bonds with the family, success in school and parents who monitor their children using clear rules of conduct. Many prevention programs attempt to strengthen these protective factors, often in the school setting.

When people feel bonded to a society or to a social unit like the family or school, they want to live according to its norms, explained the PLNDP’s Daniel Lewis, M.D. So if those norms oppose substance use, the child is more likely to decide against using.

“From NIDA-supported research, we know that comprehensive, school-based programs can reduce young children’s antisocial behavior while boosting their social competency, academic performance and commitment to school,” Volkow told Congress in April. “Unfortunately, research indicates only one in seven of the nation’s public and private schools offer prevention programs that incorporate proven elements and deliver them in the most effective way.”

The Substance Abuse and Mental Health Services Administration (SAMHSA) keeps an updated list of programs that have been proven to be effective in preventing substance use.

For example, “Across Ages” is a school- and community-based prevention program for youngsters aged nine to 13 years. The program seeks to strengthen the bond between adults and youths by pairing middle-school students with older adult mentors (age 55 and above). In addition to mentoring, the program uses community service and family activities to build kids’ sense of personal responsibility for self and community.

“Across Ages” has been shown to reduce substance use, increase problem-solving ability, increase school attendance and improve youngsters’ attitudes toward school and the

future. SAMHSA’s list can be found at <http://samhsa.gov/>

Colleges also are seeking to help their students. A growing number are following the lead of Rutgers University in New Jersey by offering special programs for students in recovery from alcohol or other substance use.

At Rutgers, about two dozen students live together in on-campus housing and help each other stay sober. The University of Texas at Austin has a Center for Students in Recovery, which offers young people a support system along with a three-credit hour academic course entitled “Complete Recovery 101.”

And Texas Tech University is creating a national model of its program, which began in 1986. That program offers scholarships to students in recovery, as well as on-campus 12-step meetings and academic support. Educators say such programs help kids stay in class and serve as a recruitment tool.

MAKING THE DIAGNOSIS

Identifying kids who have alcohol use disorders can be a useful way of finding other substance use problems and of diagnosing mental health problems, said ESAP’s Goplerud. “Alcohol is the primary drug of abuse among adolescents,” he explained. “It’s also considered a gateway into other drugs.”

Schools can help determine which kids have substance use problems by simply asking questions, he added. “When they do a sports screening, do they ask about alcohol?” he said. “When they come in to the school nurse with a headache, are they asked about alcohol? If a kid misses 15 days of school, is he or she screened for alcohol?”

Nationwide, 8 percent of kids between the ages of 12 and 20 have serious alcohol problems, according to ESAP. About one-third of those kids have a co-occurring drug use disorder. The American Academy of Pediatrics estimates that 41 to 65 percent of youngsters with a serious alcohol problem also have a mental health disorder. About 20 percent of kids (aged 15 to 20) who have a serious alcohol problem have attempted suicide.

To help policymakers determine the extent of alcohol use among adolescents in their state or community, ESAP has developed a Web-based calculator.

The calculator crunches numbers from federal databases to show roughly how many kids are drinking at hazardous levels and have never had their drinking problem detected.

It also estimates the effects on school performance, driving, contacts with law enforcement and emergency department use. Go to: www.alcoholcostcalculator.org/kids

MORE MONEY, MORE MONEY

Not surprisingly, substance use experts advocate more funding for prevention and treatment. They point out that every dollar invested in prevention saves taxpayers more than \$5, and each \$1 invested in treatment saves \$7.

In addition to funding school-based programs, the experts advise that states expand coverage of substance use treatment in Medicaid. Some states limit such coverage to acute care -- despite evidence that addiction is a chronic disease that requires a continuum of care (including outpatient care after rehabilitation).

That’s all well and good, state legislators say, but many states don’t have the money to expand treatment -- and even fewer have money for prevention, which won’t show results until a decade down the road.

“Prevention is crucial, but prevention is the first thing that’s cut,” said Iowa Sen. Maggie Tinsman. “Prevention has been cut out of almost all of our programs in Iowa, in health and in human services.”

Many of the steps that states are taking to address adult substance use disorders could help adolescents. For example, the **Hawaii** Legislature recently overrode the governor’s veto to enact legislation providing parity between coverage for physical diseases and drug and alcohol treatment.

And about 20 states have passed laws intended to stop addicts from “doctor shopping” (going to multiple doctors to get prescription drugs) by authorizing computer systems that will track prescriptions. If parents who are addicted get into treatment, their children may benefit.

But it’s difficult to stay one step ahead of the kids. One of the latest fads involves over-the-counter cough suppressants. The dextromethorphan contained in the suppressants gets the kids high, but they have to take so many pills to get that effect that ingredients such as acetaminophen can kill them. After a handful of deaths were attributed to overdoses of the pills, legislators in **New York**, **New Jersey** and **California** introduced bills to restrict the sale of products with dextromethorphan. ✦ CK

PUBLIC HEALTH NEWS

A Major Health Concern: Women & Cardiovascular Disease

Angina. Breathlessness. Chronic fatigue. Dizziness. Edema. Fluttering. Gastric upset. The ABC's of a terrible day? No, the symptoms that typify a heart attack in women.

However, few women know this. Many don't think "heart attack" unless they experience the symptoms that are typical of a heart attack in a man: a sudden pressure or squeezing in the center of the chest; pain that radiates from the center of the chest to the shoulders, neck or arms; a sudden onset of rapid heart beats.

Cardiovascular disease (which includes heart disease, heart attack and stroke) is the leading cause of death for women in all racial and ethnic groups. It kills about 500,000 women each year – that's one death every minute, and 50,000 more women who die each year from this disease than men.

Awareness is increasing, but not many women know just how deadly heart disease can be. When asked what they fear most in a recent survey on health concerns, the number one response from women was breast cancer, even though cardiovascular disease kills more than 10 times as many women each year.

Only 13 percent of women say that heart disease is their greatest personal health risk. A knowledge gap remains, especially for women younger than 45, and Hispanic and African-American women. This can be dangerous — African-American women have a 69 percent higher death rate from heart disease than Caucasian women.

Nor are many women aware that much can be done to lower their risk. Leading a healthier lifestyle can reduce heart disease risk by as much as 82 percent. By exercising and eating healthier foods, conditions that lead to

heart disease – including diabetes, high blood pressure, obesity and high cholesterol – can be controlled or even prevented.

The difference in symptoms between men and women, lack of public awareness that heart disease is the top cause of death for women, and the fact that women with cardiovascular disease may receive less counseling, screening and intensive care than men, can be killers. As a result, public-health educators and policymakers are focusing on changing perceptions, raising awareness and engaging women in lowering their risk for heart attack and stroke.

DIFFERENT STROKES

If women are unaware of their risk, so are many doctors. One in three primary-care physicians were not aware that cardiovascular disease is the leading cause of death and disability among American women, according to a study in "Making the Grade on Women's Health, 2004," published by the National Women's Law Center, the University of Pennsylvania and Oregon Health & Science University.

This lack of awareness is reflected in patient care. Overall, fewer than 50 percent of all patients will have their risk factors reliably assessed, treated or controlled, the study said. People who are aged 50 to 64, males, and non-Hispanic whites are more likely to be counseled about physical activity, diet and weight reduction than patients in other age groups, women, and non-Hispanic blacks – even though those groups are at least as likely to need crucial prevention information.

Unequal outcomes may follow a heart attack or stroke. Women are 20 percent more

likely than men to die in the hospital following a heart attack. And 38 percent of women, but only 25 percent of men, will die within one year of having a recognized heart attack. More women than men will have a second heart attack within four years of their first.

Some of these differences may be demographic – women with diagnosed cardiovascular illness are, on average, ten years older than men and generally have more coexisting medical conditions. But others may result from lack of awareness or disparate medical treatment. For example, women with cardiovascular disease are more likely to seek treatment later or to have a delayed diagnosis of cardiovascular health issues. Studies also show that women receive both less aggressive early screening for cardiovascular risk factors and less aggressive treatment for cardiovascular health problems than men. Disparities also are noticeable among racial and ethnic groups, and by socioeconomic status.

QUICK RESPONSE IS CRUCIAL

When a heart attack or stroke occurs, a quick response can prevent or limit damage. In a heart attack, the blood supply to the heart, or portions of the heart, is cut off, and the oxygen-deprived heart cells begin to die. The sooner treatment can be administered to restore blood flow, the greater the chance for recovery. Conversely, the longer the time without treatment, the greater the damage to the heart. That's why it's important to call 911 immediately.

A stroke occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts. When that happens, part of the brain cannot get the oxygenated blood that it needs, so it starts to die. Stroke is the third leading killer of U.S. women (for all racial and ethnic groups except American Indians, for whom it trails accidents and diabetes). Heart disease alone is the cause of death for one in three American women.

Research indicates that the public generally recognizes some of the warning signs for stroke. But in 2001, only 17 percent of U.S. adults recognized all five major signs of stroke. The first three are sudden numbness or weakness of the face, arm or leg(s); unexpected confusion, trouble speaking or understanding; and sudden trouble walking, dizziness, or loss of balance or coordination. Signs that are less likely to be recognized as

[Women & CVD, p.6]

PUBLIC HEALTH NEWS

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CONTRIBUTING STAFF

Glen Andersen, Steve Christian, Allison Cook, Carla Curran, Jo Donlin, Doug Farquhar, Martha King, Jeane Kaufman, Leslie Teach Robbins, Hy Gia Park, Jody Ruskamp, Lisa Speissegger, Laura Tobler, Stephanie Wasserman, Nina William-Mbengue, Amy Winterfeld

700 East First Place
Denver, CO 80230
Fax: (303) 364-7800
email: martha.king@ncsl.org

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To more fully explore the issue of cardiovascular disease in women, SHN interviewed two nationally known experts. The first interview is with Wanda K. Jones, Dr.P.H., deputy assistant secretary for health, Office on Women's Health, U.S. Department of Health and Human Services (HHS).

Q: What is the Office on Women's Health (OWH) doing to address heart disease and stroke among women?

A: The OWH is very active in educating women, health-care professionals and others about women's risk for cardiovascular disease. Under my direction, OWH was one of the founding partners of the Heart Truth Campaign led by the National Institute of Health's National Heart, Lung, and Blood Institute (NHLBI). This national campaign educates women about the dangers of heart disease, and wants women to make the connection between their risk factors, such as high blood pressure and high cholesterol, and their chance of developing heart disease.

As part of the Heart Truth Campaign, the OWH is working together with NHLBI to develop materials to educate health professionals on the diagnosis and treatment of heart disease in women.

OWH's website — www.4woman.gov — also offers information about cardiovascular disease, stroke and many other health conditions of concern to women. We have written frequently-asked questions and answers (FAQs) on over 150 women's health topics, including angina, coronary heart disease, heart-healthy eating, high blood pressure, stroke and much more. All of these documents have been written in plain language. We plan to have all of them translated into Spanish by mid-2005.

During the last four years, OWH has developed a special section on its website entitled "Heart Health." Within that section is "For Your Heart: A Personalized Program for Heart Health." This interactive program helps build women's knowledge about heart disease based on their individual responses to specific questions.

We also have two new cardiovascular disease prevention programs for women of color, aged 40 to 60 years. Each of the programs will be implemented at 25 faith-based sites (churches, mosques, etc.) throughout the U.S. Participants at each site will be committed to increasing their level of physical activity and establishing a healthy

HEALTH TALK

GETTING TO THE HEART OF HEART DISEASE IN WOMEN: TWO VIEWS

weight over the course of the program.

These programs will be based on a successful program, implemented in 2001, called Generations. It encouraged African American women in six churches around the country to reduce their risk for cardiovascular disease. The Association of Black Cardiologists conducted this pilot program.

Q: Why are so many women unaware that cardiovascular disease is their #1 health risk?

A: At least part of the reason is that women's health has been viewed historically as reproductive health and breast cancer. Only within the last three to five years has a more holistic view of women emerged in many healthcare settings. With that view comes the knowledge that women are affected by, and afflicted with, many diseases and health conditions, including cardiovascular disease. In addition, cardiovascular disease is still perceived by some health professionals to strike only much older women.

Q: What kinds of changes are needed in our health-care system to better respond to women who are victims of heart attack and stroke?

A: Among many other things, all health professions' training curricula should be evidence-based and reflect that heart disease and stroke are the #1 and #3 killers, respectively, of all American women, that women can exhibit different symptoms of a heart attack than do men, and that women may need a different approach to treatment than do men.

The second interview is with Janet D. Lawson, M.D., the Texas state liaison to the HHS Office on Women's Health.

Q: How prevalent is heart disease in your state?

A: In Texas, cardiovascular disease has been the leading cause of death for women since the 1940's, accounting for two out of every five deaths. In 2001, there were 21,660 women who died from heart disease; 6,600 women died from strokes.

Q: Why are so many women unaware that cardiovascular disease is their #1 health risk?

A: I suspect that there are several reasons. We did a great job educating women about their risks for breast cancer, as we in-

vested in public awareness campaigns encouraging women to see their doctors for clinical breast exams and to be scheduled for mammograms. We did so much that women may not have realized that there are other important conditions of which they should be aware, like heart disease and stroke.

On a separate front, probably because men die an average of ten years earlier than women from heart disease, over the past three decades, we spent most of our effort trying to reduce cardiovascular deaths in men — with, I might add, fairly good success. In Texas and nationally, we've seen a decline in the number of cardiovascular deaths in men, and now more women are dying of heart attacks than men.

Q: What is Texas doing to raise awareness of women's risk for heart disease and stroke?

A: The Texas Council on Cardiovascular Disease and Stroke outlines strategies to address cardiovascular disease in Texas. These strategies include: **Surveillance** — we need to know where we are starting and to follow the impact of any interventions. **Health education and outreach** — we are working to make folks more aware of their risks and provide information to change their behaviors to decrease those risks that can be modified. **Clinical prevention and treatment services** — we focus on health-care providers to ensure that screening, diagnosis and appropriate treatment are provided. And, **Community policy and environmental changes** — we want folks to exercise more, eat better and smoke less. Communities can help by having safe areas, like hike and bike trails, parks and public facilities; better nutrition and more physical education programs (across all ages) in the schools; and more non-smoking ordinances.

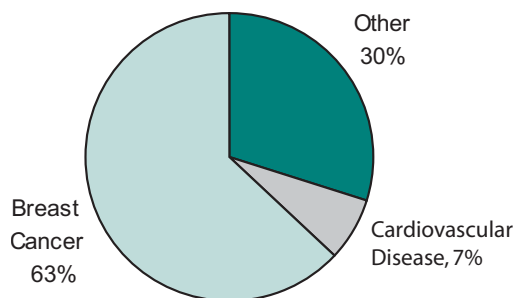
Q: How can individual women reduce their risk for cardiovascular disease?

A: Women can definitely take steps to decrease their risk of heart disease. If they don't smoke or use tobacco products, they shouldn't start and if they do, then they should stop. They should develop and maintain a regular routine of physical activity. This can be as simple as adding a regular walking routine for at least 30 minutes each day, at least five days each week.

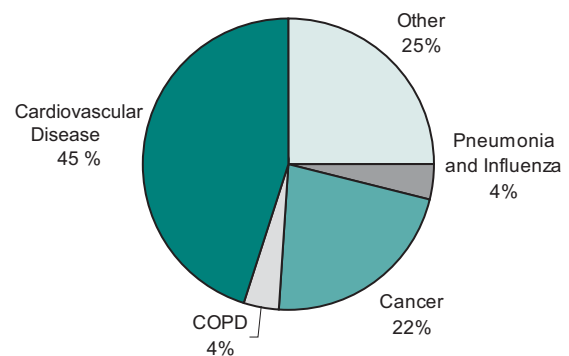
They should eat a healthy, balanced diet that is low in fat and contains five or more servings of fruits and vegetables each day. And they should have regular doctor visits that include monitoring of blood pressure, cholesterol and weight. + AW

Women and Cardiovascular Disease

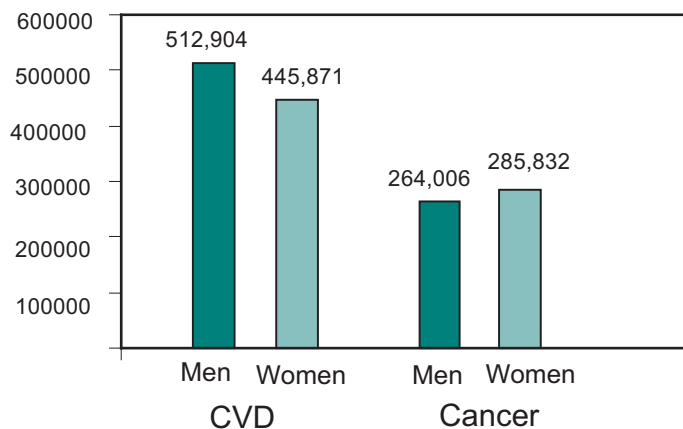
Perception: Major Causes of Death



Reality: Causes of Death in Women



Deaths by Sex and Cause



Fast Facts:

- There are more hospital discharges among women for CVD than any other cause;
- 38% of women compared to 25% of men die within one year of having a heart attack;
- The cost associated with CVD in women is more than 25 times the costs associated with breast cancer and all gynecological cancers combined.

Compared to men:

- Women are 20% more likely to die in the hospital following a heart attack;
- Women are more likely to have a 2nd heart attack within four years of the first one;
- Women are more likely to present later and/or have a delay in diagnosis;
- Women are often treated less aggressively in ERs and post-discharge.

Source: Texas Department of Health, 2004

stemming from a possible stroke are trouble seeing in one or both eyes, and sudden, severe headache with no known cause. Some members of the public also confuse the signs of heart attack with those of stroke; approximately 38 percent incorrectly assume that sudden chest pain is a sign of a stroke.

PREVENTION IS BEST

"To build a heart-healthy and stroke-free world, we need to use a strong public policy approach and community mobilization as major tools against the devastating health and economic effects of heart disease," says George Mensah, MD, chief of the cardiovascular health branch at the Centers for Disease Control and Prevention (CDC). These can be used as major tools against the devastating health and economic effects of heart disease.

Foundations, state and federal governments and schools and private employers are taking action. For example, the American Heart Association's "Go Red for Women" campaign seeks to provide women with positive messages about cardiovascular health. It informs women that they have the power to keep their hearts healthy for a lifetime by: 1) Learning the warning signs of heart attack and stroke; 2) Tracking cholesterol, blood pressure and weight; 3) Scheduling a check up with a health-care professional; and 4) Following health care professional recommendations, including taking prescribed medications.

In another effort, on Feb. 2, First Lady Laura Bush launched the "Heart Truth Road Show," sponsored by the National Heart, Lung, and Blood Institute. The road show brought heart health screening and information to women in Philadelphia, Chicago, San Diego, Dallas and Miami. The Heart Truth's Red Dress collection, featuring a display of designer red dresses, was intended to alert women that "Heart Disease Doesn't Care What You Wear – It's the #1 Killer of Women."

The Steps to a Healthier US initiative of the U.S. Department of Health and Human Services is aimed at marshalling resources and partners to address health risk factors. A com-

prehensive "blueprint" recently issued by the initiative calls for HHS to collaborate with outside organizations to promote healthy habits and chronic disease prevention. It challenges individuals and interested groups to take simple steps to promote healthy lifestyles, such as walking 30 minutes each day.

At the state level, policymakers can help by supporting public health education efforts. Legislative resolutions can give official recognition to efforts such as "heart health month." Legislators also can work with health departments to sponsor public awareness campaigns about the signs and symptoms of heart disease and stroke and the importance of a swift emergency response.

In 1998, the CDC initiated the State Heart Disease and Stroke Prevention Program, a national, state-based program that was originally funded in eight states, and has since been expanded to 32 states and the District of Columbia. The program helps states to plan, implement, track and sustain population-based interventions that address cardiovascular disease and related risk factors (such as high blood pressure, high cholesterol, tobacco use, physical inactivity and poor nutrition).

States are taking a variety of approaches. In Utah, heart disease is the leading cause of death, and accounted for about 23 percent of the state's deaths in 2001. CDC funds have helped the state Department of Health to develop a heart disease and stroke prevention program. Among other things, Utah has developed a hypertension self-management kit in both English and Spanish for newly diagnosed hypertensive patients. The kit includes a video that explains what high blood pressure is and why control of it is so important, self-tracking tools, an information guide and a plan for nutritious eating. The kits are distributed to federally funded community health centers, health plans that serve Medicaid populations and other primary-care networks for low-income populations. For more, go to www.hearhighway.org

Heart disease is the second leading cause of death in Alaska, causing about 20 percent

of the state's deaths in 2003. With its CDC funds, the Alaska Department of Health formed the "Take Heart Alaska Coalition" to advocate for individual, worksite and community-based improvements to lifestyles and improving access to preventive services. The Alaska Women Take Heart Coalition launched a statewide campaign to teach the public the signs and symptoms of a heart attack in women, created an educational kit for distribution to hospitals, nurses and others; and helped develop protocols for tracking cholesterol and blood pressure in rural clinics. Go to <http://partners.hss.state.ak.us/takeheart/>

Heart disease is the leading cause of death in Kentucky, accounting for about 30 percent of the state's deaths in 2001. Among other things, the state is working with the state affiliate of the American Heart Association (AHA), the Kentucky Hospital Association and the American College of Cardiology to improve hospital-based health outcomes through the AHA's "Get with the Guidelines-CAD" (coronary artery disease) program. More than 57 hospitals sent representatives to the Get with the Guidelines-CAD conferences, and 26 hospitals actively participated in quality improvement efforts. The Kentucky Department of Public Health and Health Care Excel Inc. also created and distributed packets on the guidelines to practitioners and local district health departments. Visit <http://chs.state.ky.us/publichealth/cardiovascular.htm>

Both employers and schools can contribute to the fight against cardiovascular disease. Employers can reap savings in health insurance costs by training workers in the signs of heart attack and stroke, making worksites smoke-free and providing healthy food choices on-site. Schools can provide nutrition education and encourage physical activity or formal physical education. Presenting students with nutritious food choices also promotes development of good cardiovascular health habits. Faculty and students can be trained in CPR through after-school programs or for extra credit.

—AW

STATE HEALTH NOTES

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RESEARCH & EDITORIAL STAFF

Dick Merritt Forum Director
Christina Kent Managing Editor
Anna C. Spencer Associate Editor
Contributors: Allison Colker, Donna Folkemer, Wendy Fox-Grage, Shelly Gehshan, Tim Henderson, Michelle Herman, Diana Hinton, Kala Ladenheim, Greg Martin, Anna B. Scanlon

EDITORIAL INQUIRIES

Christina Kent, Managing Editor
Tel: 202-624-5400 • Fax: 202-737-1069
email: christina.kent@ncsl.org

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HIGHLIGHTS

MEDICAID

Nursing Home Coverage Drops

Starting in July, **Georgia** will end an optional program that extends Medicaid coverage to people with incomes that are high enough to disqualify them from traditional Medicaid, but too low to pay for long-term care. Nearly 2,000 nursing home residents are expected to lose coverage. To avoid losing their coverage, beneficiaries can create a special trust allowed under state rules. Income in these so-called qualified income or Miller trusts is not counted when determining Medicaid eligibility. Medicaid covers the difference between what the beneficiary and trust pay and what the nursing home charges beneficiaries. Georgia estimates that eliminating the program will save up to \$10 million in the next fiscal year, although actual savings could be significantly smaller because the state Department of Community Health did not take into consideration the number of residents who will establish Miller trusts, reports the *Atlanta Journal-Constitution*.

Monthly Premiums Delayed

On June 8, **Washington** Gov. Gary Locke announced that he will delay by one year the institution of monthly premiums for children enrolled in Medicaid. Under the proposed plan, premium notices would have been sent to families by July 1 and payment due on July 15. Families with incomes between 150 and 200 percent of the federal poverty level (\$23,500 to \$31,300 for a family of three) would have been required to pay \$10 per month per child, up to \$30 per family. Proposed premium increases for families earning between 200 and 250 percent of the FPL will not be delayed. Those monthly premiums will increase from \$10 to \$15 per child, up to a maximum of \$45 per household per month. Locke noted that the premiums,

which were expected to raise \$4 million for the state, were no longer necessary because the state expects to save \$12 million over the next biennium through new eligibility requirements (See *SHN* 421, 5/31/04 for more on Washington's Medicaid cost-containment strategies.)

CHILDREN'S HEALTH

Suicide Rate Down

The suicide rate among U.S. children and teenagers decreased by 25 percent between 1992 and 2001, according to a report released June 10 by the Centers for Disease Control and Prevention. According to the report, the suicide rate among U.S. residents aged 10 to 19 decreased from 6.2 deaths per 100,000 in 1992 to 4.6 per 100,000 in 2001, and the total number of suicides decreased from 2,151 to 1,883 over the same period. The decrease in gun suicides was marked among children 10 to 14, dropping from 172 in 1992 to 90 in 2001. Among those 15 to 19, deaths from self-inflicted shootings dropped from 1,251 to 838 during the same period, the CDC said. Researchers posit that restrictions on children's access to firearms and the decreased stigma surrounding sexual orientation contributed to the decrease.

ORAL HEALTH

Black Men Suffer

According to a June 16 report from the Joint Center for Political and Economic Studies' Health Policy Institute, African American men have a "high rate of irreversible gum disease" and "serious dental decay." According to the report, 51 percent of black men have untreated tooth decay, compared to 28 percent of white men. Black men also are 1.5 times more likely than white men to have missing teeth and on average, last visited

a dentist nearly four years ago. These findings are significant as African American men have the nation's highest incidence of oral cancer and the lowest survival rates, a condition and outcome that are closely linked to poor dental health. The report recommends several policy options for federal and state governments, dental schools, and private companies including: developing standards for access to dental care for priority populations; providing flexible loan repayment strategies for dental providers in communities of color or areas short of dental health professionals; including oral health referral services in discharge plans for correctional facilities; and requiring commercial insurers and Medicaid to include "annual dental visit" as part of their health plan benefits. For a copy of *Visible Differences: Improving the Oral Health of African American Males* visit www.jointhehealth.org

END-OF-LIFE CARE

Hospice for the Homeless

On June 17, the Abbie Hung Bryne Home became the first residence in Indianapolis, **Indiana**, for people who are terminally ill and homeless. The \$1.4 million home was founded by the Visiting Nurse Service to provide comfort for the homeless in their last days. Modeled after the Malachi House, a Catholic-based program in **Ohio**, the three adjoining townhouses can serve up to 12 people at one time, and will be rely upon volunteers to provide food, laundry, clothing, transportation and companionship for residents. A VNS survey estimates that there are between 150 and 400 terminally ill homeless people a year in Indianapolis; 50 to 60 people will receive services from the Bryce Home each year. Private contributions and foundation grants will help pay for the \$300,000 yearly operating costs. For more details call (317) 722-8200.

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Rumble in the Farmland:

Communities Fight Youth Gangs

The term “gang” often conjures up images of hardened, “colors”-wearing, young street toughs, who claim blocks of inner-cities as their “turf.” But, as many communities are discovering, today’s gangs are not just in big cities any more.

Increasingly, residents of suburban communities, smaller cities and rural areas find themselves in the midst of gang activity. The National Youth Gang Survey found that 100 percent of large cities, 47 percent of suburban counties, 27 percent of small cities, and 18 percent of rural counties reported gang activity in 1999.

The newer gangs in smaller communities tend to differ considerably from their predecessors. “Modern” gang members are often younger than their predecessors and gangs are more likely to be mixed in race and ethnicity. While males are still more heavily involved, female gang membership is on the rise and many gangs comprise both sexes. According to the Office of Juvenile Justice and Delinquency Prevention (OJJDP), at the U.S. Department of Justice, roughly 40 percent of youth gangs have female members.

There’s good news: many youngsters are loosely attached to multiple gangs or are only briefly associated with them. The groups also are less territorial, less likely to be involved in drug trafficking and criminal activity, and may be smaller and more school-centered.

But the National Youth Prevention Resource Center estimates that there are 24,500

gangs across the nation, with nearly 800,000 teenaged members. While gang activity declined between 1996 and 1998, it is on the rise again, and gang homicides rose by more than 50 percent between 1999 and 2002.

Some experts fear that the newer gangs are less involved in criminal activity than traditional gangs only because they are less developed, and that over time criminal behavior will increase. Furthermore, gang membership remains a significant risk factor for involvement in violence, selling or using drugs, and weapon possession. One study found that gang membership at age 14 more than tripled the risk for involvement in violence, and schools with gang activity have higher rates of violence than schools that report no gang presence. According to the CDC, homicide is the second leading cause of death among youngsters aged 10 to 24, and more than 877,700 young people were injured by violent acts in 2002.

WHAT CAN COMMUNITIES DO?

One answer is “Fight Crime: Invest in Kids.” A national organization of police chiefs, sheriffs, prosecutors and victims of violence with programs in five states – **California, Illinois, Michigan, New York and Pennsylvania** – “Fight Crime” is dedicated to finding proven interventions to prevent young people from getting involved in crime. This month the organization released a report, *Caught in the Crossfire: Arresting Gang Violence By Investing in Kids*, that outlines effective strategies for dealing with existing gangs now, keep-

ing troubled youngsters out of gangs, and shutting off the pipeline early to prevent future gang membership.

The report discusses both how to deal with existing gangs and how to prevent draft-ees from joining. “Serious violent criminals need to be locked up, but to curb gang violence we must intervene to keep these kids from becoming criminals in the first place,” said Los Angeles Police Chief Bill Bratton. The report discusses major initiatives in cities such as Boston and Philadelphia that have dramatically reduced gang violence by using law enforcement while providing intensive support services for high-risk youth, helping them gain employment, stay in school and stay away from drugs.

These approaches can help jurisdictions deal with gang activity in their communities, but keeping kids from joining gangs is the most effective way to prevent gang violence. To that end “Fight Crime” recommends that communities look at interventions such as family therapy for chronic juvenile offenders and early interventions for kids not involved gangs.

The **Washington State** Legislature found that family therapy is effective and can save taxpayers \$29 for every dollar spent, and that some pre-school initiatives made children five times less likely to become chronic lawbreakers. States can help discourage future gang membership by supporting kids at a young age, and communities can look to some of these proven interventions to tackle the problem of gang violence today. **+ AS**

For more, visit www.fightcrime.org

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